

NEVADA STATE BOARD OF MEDICAL EXAMINERS FEES FOR SPECIAL PURPOSE MEDICAL LICENSURE BETWEEN JULY 1, 2013 AND JUNE 30, 2015

ONLY original applications for licensure sent from The Nevada State Board of Medical Examiners or downloaded online applications will be accepted. Any applications which appear to have been altered in any form will not be accepted. Applications must be typed or legibly handwritten in ink (illegible or incomplete applications will be returned). Applications must be received on single-sided, white bond paper, 8 ½" x 11" in size. Applications not completed within six (6) months from date of receipt will be rejected per NAC 630.180(2).

Fees applicable July 1, 2013 – June 30, 2014:

\$400 Application Fee \$800 Registration Fee \$75 Criminal Background Investigation Fee = \$1,275.00

Fees applicable July 1, 2014 – June 30, 2015:

\$400 Application Fee \$400 Registration Fee \$75 Criminal Background Investigation Fee = \$ 875.00

You may pay by cashier's check or money order, payable to "NEVADA STATE BOARD OF MEDICAL EXAMINERS," or by credit card. If paying by credit card, please complete the Credit Card Authorization form on the last page of this application. A two percent (2%) service fee will be assessed for payment by credit card.

The Application fee and Criminal Background Investigation fee will not be refunded.

A Special Purpose Medical License can be issued to a physician who is licensed in another state to perform any of the acts described in subsections 1 and 2 of NRS 630.020 by using equipment that transfers information concerning the medical condition of a patient in this State electronically, telephonically or by fiber optics from within or outside this State or the United States if the physician:

- Holds a full and unrestricted license to practice medicine in that state;
- Has not had any disciplinary or other action taken against him or her by any state or other jurisdiction; and
- Is certified by a specialty board of the American Board of Medical Specialties or its successor.

PLEASE BE AWARE: A physician who holds a Special Purpose Medical License is only authorized to practice medicine electronically, telephonically or by the use of fiber optics. The practice of medicine is defined by NRS 630.020(3) as follows:

1. To diagnose, treat, correct, prevent or prescribe for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality.
2. To apply principles or techniques of medical science in the diagnosis or the prevention of any such conditions.
3. To perform any of the acts described in subsections 1 and 2 by using equipment that transfers information concerning the medical condition of the patient electronically, telephonically or by fiber optics from within or outside this State or the United States.

Per Nevada Revised Statute 630.161, "The Board shall not issue a license to practice medicine to an applicant who has been licensed to practice any type of medicine in another jurisdiction and whose license was revoked for gross medical negligence by that jurisdiction."

The Board's staff conducts an investigation into your background during the application process. If staff becomes aware of circumstances** warranting a personal appearance at a Board meeting prior to acceptance of your application for licensure, your application must be completed 45 days prior to any regularly scheduled Board meeting in order for your appearance to be scheduled for that meeting for consideration of acceptance of your application. Under Nevada law, a public body cannot hold a meeting to consider the character, alleged misconduct, professional competence, or physical or mental health of any person unless it has given written notice to that person of the time and place of the meeting. The written notice must be sent by certified mail to the last known address of that person at least 21 working days before the meeting. A public body must receive proof of service of the notice before such a meeting may be held.

**** You may be required to personally appear before the Board for acceptance of your application for licensure if you have in any way ever been involved in any malpractice awards, judgments, or settlements in any amount.**

**** You may be required to personally appear before the Board for acceptance of your application for licensure if you have answered in the affirmative ("Yes") to questions 8, 9, 10, 11, 12, 12a, 13, 19, 25, 26, 27, 28, 29, 30, and/or 31.**

If, at the time you meet with the Board, the Board votes to deny or not accept your application for licensure, this denial or non-acceptance of your application may become a reportable action to the Healthcare Integrity and Protection Data Bank, Federation of State Medical Boards of the United States, Inc. and American Medical Association, among other entities.

SPECIAL PURPOSE PHYSICIAN APPLICATION CHECKLIST

TO BE RETURNED DIRECTLY TO BOARD OFFICE BY APPLICANT

_____	a.	APPLICATION: <ul style="list-style-type: none"> <input type="checkbox"/> Properly completed, signed and notarized application, including pages 1 – 6, Applicant Responsibility statement, and Criminal Background Investigation report authorization form; <input type="checkbox"/> Recent passport quality photograph (at least 2”x 2”) attached to application, signed in ink on lower front edge; <input type="checkbox"/> Appropriate explanations and copies of all pertinent documentation must be attached for affirmative responses to questions numbered 8, 9, 10, 11, 12, 12a, 13, 14, 19, 25, 26, 27, 28, 29, 30 and/or 31; <input type="checkbox"/> Release form, signed and notarized (Form A);
_____	b.	FEES: <ul style="list-style-type: none"> • Proper application, registration, AND criminal background investigation fees – cashier’s check or money order made payable to Nevada State Board of Medical Examiners (NSBME) or by credit card as instructed. Credit cards will only be accepted by receipt of the signed credit card authorization form. <p>Note: Application and criminal background investigation fees are <u>non-refundable</u>;</p>
_____	c.	IDENTITY (important identity documents will be returned to you via secured mail): <ul style="list-style-type: none"> • U.S. born citizens – Original or Certified Birth Certificate that bears an original seal or stamp of the issuing agency (notarized copies are not acceptable); • Foreign-born citizens - Original Certificate of Naturalization or current U.S. Passport; • Non U.S. citizens - Copy of both sides of Alien Registration card or Employment Authorization card or Visa;
_____	d.	SELF-QUERY VERIFICATION: <ul style="list-style-type: none"> • Self-query response from the National Practitioner Data Bank (NPDB); see enclosed instruction sheet. The NPDB will send the report directly to you and you will forward <u>the final report</u> to the Board office;
_____	e.	SUPPLEMENTARY FORMS: <ul style="list-style-type: none"> • FORM B: ONLY if you have answered affirmatively to either of the two malpractice questions on the application;
_____	f.	CONTINUING EDUCATION: <ul style="list-style-type: none"> • Proof of 4 hours bioterrorism <u>AMA Category 1</u> continuing medical education (CME) relating to the medical consequences of an act of terrorism that involves the use of a weapon of mass destruction. Search for an online course by entering “AMA Category 1 bioterrorism continuing medical education” or take a classroom course;
_____	g.	EXAMINATION REGARDING NEVADA LAW GOVERNING YOUR MEDICAL PRACTICE: <ul style="list-style-type: none"> • Jurisprudence examination familiarizing you with the Medical Practice Act (Nevada Revised Statutes Chapters 630 and 629 and Nevada Administrative Code Chapter 630) will be mailed to you upon acknowledgement of receipt of your application and appropriate fees. You must answer correctly at least 75% of the questions.

SPECIAL PURPOSE PHYSICIAN APPLICATION CHECKLIST

DIRECT SOURCE VERIFICATIONS TO BE SOLICITED BY APPLICANT FOR DIRECT RETURN BY THE VERIFYING INSTITUTION TO BOARD OFFICE

_____	*	a.	MEDICAL SCHOOL: <input type="checkbox"/> Verification of Medical Education (Form 1) to be completed by medical school(s); <input type="checkbox"/> Official transcripts from all schools where professional medical instruction was received (if transcripts are not in English, a certified original and official English translation is required);
_____	*	b.	POSTGRADUATE TRAINING PROGRAM: <ul style="list-style-type: none"> • Certificate of Completion of Progressive Postgraduate Training (Form 2) to be completed by <u>all</u> institutions where any training occurred (internship, residency, fellowship and research fellowship);
_____	*	c.	EXAMINATION: <input type="checkbox"/> Certification of National Board, FLEX, USMLE, LMCC or SPEX scores - see instruction page; <input type="checkbox"/> Certification status report from the Educational Commission for Foreign Medical Graduates (ECFMG) – see instruction page;
_____		d.	BOARD CERTIFICATION: <ul style="list-style-type: none"> • Direct source verification of American Board of Medical Specialties (ABMS) Board certification;
_____		e.	LICENSE VERIFICATIONS: <ul style="list-style-type: none"> • License verification (Form 3) from <u>all</u> states where applicant is currently licensed or has ever been licensed (this does not include training licenses or temporary permits);
_____		f.	MALPRACTICE INSURANCE CARRIER VERIFICATIONS: <ul style="list-style-type: none"> • Malpractice insurance carrier verification (Form 6) to be completed by appropriate entity and returned directly by the verifying institution to the Board office and must include the loss history report for any and all malpractice cases that occurred within the past 10 years (see Disclaimer below);
_____		g.	FINGERPRINTS: <ul style="list-style-type: none"> • FBI Criminal history background report – returned directly by the verifying institution to the Board office. (Once application fees have been received, a fingerprint card and instructions will be mailed to the applicant. Note: The Board fingerprint card contains the necessary Board account numbers required for processing.)

Verifying agencies may charge a fee. Do not provide pre-stamped or pre-addressed envelopes for direct source verifications.

* Federation Credentials Verification Service (FCVS) packet may verify these documents.

Disclaimer: Per Nevada Revised Statute 630.173(2), the Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old.

APPLICATION GUIDE

Identity - Licenses will be issued in the applicant's name as it is indicated on the submitted documented proof of such name (i.e., U.S. Birth Certificate, Certificate of Naturalization, Alien Registration card, Employment Authorization card, and/or other legal documentation reflecting name change).

Postgraduate Training - If you have ever had any actions, forms of remediation, restrictions or limitations imposed on you, or have been placed on probation while participating in any type of training program, you should answer affirmatively to question #19. Submit a signed and dated explanation addressed to the Board and copies of documentation you received from your program.

[i.e., explanation addressed to the Board for any postgraduate training issues.]

Malpractice - Provide signed and dated explanations for all malpractice cases throughout your career. Provide copies of legal documentation for malpractice cases that occurred within the past 10 years unless otherwise instructed which includes copies of Complaints, Settlements and/or Dismissals. If you have a pending case or cases, request a letter from your attorney to be sent directly to the Board describing the current status of the case(s).

[i.e., explanations for all cases addressed to the Board during your medical career answering who, what, where, when and why; copies of legal documents for the past 10 years.]

Investigation - If you have ever been notified that you were under investigation by any medical licensing board, hospital, medical society, governmental entity or other agency, whether or not you were charged with or convicted of any violations of a statute, rule or regulation governing your practice as a physician, you should answer affirmatively to question #31 and submit the appropriate documentation. Provide signed and dated explanations and copies of any related documentation you received regarding any investigation that occurred within the past 10 years unless otherwise instructed.

[i.e., explanation addressed to the Board and copies of documentation for the past 10 years.]

VERIFICATIONS THAT MAY BE EXPECTED FROM A DIRECT SOURCE OTHER THAN WHAT IS OUTLINED ON THE CHECKLIST

- Observerships, Externships, Research positions or Research Fellowships prior to completion of your postgraduate training in the United States or Canada.
- Employment in a medical setting between medical school and postgraduate training or in between postgraduate training years and prior to completion of your postgraduate training in the United States or Canada.

Disclaimer: Per Nevada Revised Statute 630.173(2), the Board has the right to consider information that is more than 10 years old regarding malpractice, investigations by another licensing board, complaints or disciplinary actions from a hospital, clinic or medical facility if the Board receives the information from the applicant or any other source from which the Board is verifying the information provided by the applicant.

ATTENTION APPLICANT!

RESPONSIBILITY STATEMENT

Please sign and return this statement with your application for licensure to:
The Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510
or
1105 Terminal Way, Ste 301, Reno, NV 89502

Because you are applying for the privilege of practicing medicine in Nevada, you should know that our state has some of the most stringent licensing requirements and comprehensive investigation programs in the United States.

Via FBI fingerprinting and other investigative modalities, our licensing specialists are likely to discover if data you have submitted on your application is erroneous or incomplete; therefore, you must answer all questions truthfully and completely. Specifically, this includes any sanctions or disciplinary actions you may have experienced during medical school or your postgraduate training, or any involvement you may have had with the legal system, either civil or criminal — criminal to include charges that may have ultimately been expunged, lessened, or dismissed, and no matter how long ago the event(s) occurred.

Explaining and documenting a problem to your licensing specialist will be much less painful than discussing your veracity before the entire Board of Medical Examiners due to inconsistencies between your application and incongruent input from outside sources.

ONLY YOU — NOT A LAWYER, DOCTOR, SPOUSE, OR CREDENTIALING COMPANY — ARE RESPONSIBLE FOR READING AND ANSWERING EVERY QUESTION ACCURATELY AND COMPLETELY.

If you have *any* questions about your application, ASK YOUR LICENSING SPECIALIST. Our licensing specialists are here to help you.

○ ○ ○ ○ ○

I have read this responsibility statement and understand that I alone am accountable for completing my application for medical licensure in Nevada.

Print your name _____

Sign your name _____

Date _____

Note: It is your responsibility to keep the Board informed of any circumstance or event that would require a change to your initial responses provided to the Board in your application for licensure, and which occurs prior to you being granted licensure to practice medicine in the state of Nevada.

INSTRUCTIONS FOR REQUESTING EXAM SCORES, “BOARD ACTION HISTORY REPORT” AND NATIONAL PRACTITIONER DATA BANK “SELF QUERY”

NATIONAL PRACTITIONER DATA BANK’S “PRACTITIONER REQUEST” FOR INFORMATION DISCLOSURE (SELF-QUERY):

The request form for the National Practitioner Data Bank (NPDB) is available at <http://www.npdb.hrsa.gov>. Click on “How to Get Started” under the Practitioners column on the left side of the page and follow the instructions provided. If you require additional information, please call the NPDB at (800) 767-6732. Once you have received the final report or self-query response from the NPDB, forward a copy of this report to the Board office.

FLEX, SPEX and USMLE AND BOARD ACTION HISTORY REPORT (EBAHR) FROM THE FEDERATION OF STATE MEDICAL BOARDS OF THE UNITED STATES

The Federation of State Medical Boards of the United States, Inc.’s EBAHR will certify a complete history of your scores for a designated examination(s). The Federation maintains scores for FLEX, SPEX, and the USMLE Steps 1, 2, and 3. Request transcripts online at www.fsmb.org/transcripts.html. For questions or assistance, please call (817) 868-4041 or email usmle@fsmb.org.

NATIONAL BOARD SCORES:

NBME scores must be received directly from the National Board of Medical Examiners. The request form for the National Board of Medical Examiners is available on the NBME web site: <https://apps.nbme.org/ciw2/prod/jsp/login.jsp>. If you have difficulty accessing the form, please call the NBME at (215) 590-9592.

LMCC EXAMINATION TRANSCRIPT OF SCORES

Navigate to this website: www.mcc.ca. Click on **English**; go to **MCC documents** on the menu line; then go to **Certified Transcript of Examinations**. Click on **Service Request Form**. Print the Service Request Form and complete it. Mail it along with your check to the address on the top of the form. Or, if you are paying by credit card, you can fax the form to the fax number located on the form itself and also on the instruction page. For questions or assistance, please call (613) 521-6012.

ECFMG VERIFICATIONS

International medical graduates must contact the ECFMG for certification status to be sent to the Nevada State Board of Medical Examiners. You can contact ECFMG’s Applicant Information Services at (215) 386-5900. The request form can be found on ECFMG’s website at www.ecfm.org. If you are using FCVS, you do not need to contact the ECFMG; FCVS will coordinate with the ECFMG to obtain your certification.

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065:

NRS 630.301 Criminal offenses; disciplinary action taken by other jurisdiction; surrender of previous license while under investigation; malpractice; engaging in sexual activity with patient; disruptive behavior; violating or exploiting trust of patient for financial or personal gain; failure to offer appropriate care with intent to positively influence financial well-being; engaging in disreputable conduct; engaging in sexual contact with surrogate of patient or relatives of patient. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Conviction of a felony relating to the practice of medicine or the ability to practice medicine. A plea of nolo contendere is a conviction for the purposes of this subsection.
 2. Conviction of violating any of the provisions of [NRS 616D.200](#), [616D.220](#), [616D.240](#), [616D.300](#), [616D.310](#), or [616D.350](#) to [616D.440](#), inclusive.
 3. Any disciplinary action, including, without limitation, the revocation, suspension, modification or limitation of a license to practice any type of medicine, taken by another state, the Federal Government, a foreign country or any other jurisdiction or the surrender of the license or discontinuing the practice of medicine while under investigation by any licensing authority, a medical facility, a branch of the Armed Services of the United States, an insurance company, an agency of the Federal Government or an employer.
 4. Malpractice, which may be evidenced by claims settled against a practitioner, but only if the malpractice is established by a preponderance of the evidence.
 5. The engaging by a practitioner in any sexual activity with a patient who is currently being treated by the practitioner.
 6. Disruptive behavior with physicians, hospital personnel, patients, members of the families of patients or any other persons if the behavior interferes with patient care or has an adverse impact on the quality of care rendered to a patient.
 7. The engaging in conduct that violates the trust of a patient and exploits the relationship between the physician and the patient for financial or other personal gain.
 8. The failure to offer appropriate procedures or studies, to protest inappropriate denials by organizations for managed care, to provide necessary services or to refer a patient to an appropriate provider, when the failure occurs with the intent of positively influencing the financial well-being of the practitioner or an insurer.
 9. The engaging in conduct that brings the medical profession into disrepute, including, without limitation, conduct that violates any provision of a code of ethics adopted by the Board by regulation based on a national code of ethics.
 10. The engaging in sexual contact with the surrogate of a patient or other key persons related to a patient, including, without limitation, a spouse, parent or legal guardian, which exploits the relationship between the physician and the patient in a sexual manner.
 11. Conviction of:
 - (a) Murder, voluntary manslaughter or mayhem;
 - (b) Any felony involving the use of a firearm or other deadly weapon;
 - (c) Assault with intent to kill or to commit sexual assault or mayhem;
 - (d) Sexual assault, statutory sexual seduction, incest, lewdness, indecent exposure or any other sexually related crime;
 - (e) Abuse or neglect of a child or contributory delinquency;
 - (f) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in [chapter 454](#) of NRS; or
 - (g) Any offense involving moral turpitude.
- (Added to NRS by 1977, 824; A 1981, 590; 1983, 305; 1985, 2236; 1987, 197; 1991, 1070; 1993, 782; 1997, 684; 2001, 766; 2003, 2707, 3433; 2003, 20th Special Session, 264, 265; 2005, 2522; 2007, 3045; 2011, 847)

NRS 630.304 Misrepresentation in obtaining or renewing license; false advertising; practicing under another name; signing blank prescription forms; influencing patient to engage in sexual activity; discouraging second opinion; terminating care without adequate notice. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Obtaining, maintaining or renewing or attempting to obtain, maintain or renew a license to practice medicine by bribery, fraud or misrepresentation or by any false, misleading, inaccurate or incomplete statement.
 2. Advertising the practice of medicine in a false, deceptive or misleading manner.
 3. Practicing or attempting to practice medicine under another name.
 4. Signing a blank prescription form.
 5. Influencing a patient in order to engage in sexual activity with the patient or with others.
 6. Attempting directly or indirectly, by way of intimidation, coercion or deception, to obtain or retain a patient or to discourage the use of a second opinion.
 7. Terminating the medical care of a patient without adequate notice or without making other arrangements for the continued care of the patient.
- (Added to NRS by 1983, 301; A 1985, 2236; 1987, 198)

NRS 630.305 Accepting compensation to influence evaluation or treatment; inappropriate division of fees; inappropriate referral to health facility, laboratory or commercial establishment; charging for services not rendered; aiding practice by unlicensed person; delegating responsibility to unqualified person; failing to disclose conflict of interest; failing to initiate performance of community service; exception.

1. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:
 - (a) Directly or indirectly receiving from any person, corporation or other business organization any fee, commission, rebate or other form of compensation which is intended or tends to influence the physician's objective evaluation or treatment of a patient.
 - (b) Dividing a fee between licensees except where the patient is informed of the division of fees and the division of fees is made in proportion to the services personally performed and the responsibility assumed by each licensee.
 - (c) Referring, in violation of [NRS 439B.425](#), a patient to a health facility, medical laboratory or commercial establishment in which the licensee has a financial interest.
 - (d) Charging for visits to the physician's office which did not occur or for services which were not rendered or documented in the records of the patient.
 - (e) Aiding, assisting, employing or advising, directly or indirectly, any unlicensed person to engage in the practice of medicine contrary to the provisions of this chapter or the regulations of the Board.
 - (f) Delegating responsibility for the care of a patient to a person if the licensee knows, or has reason to know, that the person is not qualified to undertake that responsibility.
 - (g) Failing to disclose to a patient any financial or other conflict of interest.
 - (h) Failing to initiate the performance of community service within 1 year after the date the community service is required to begin, if the community service was imposed as a requirement of the licensee's receiving loans or scholarships from the Federal Government or a state or local government for the licensee's medical education.
 2. Nothing in this section prohibits a physician from forming an association or other business relationship with an optometrist pursuant to the provisions of [NRS 636.373](#).
- (Added to NRS by 1983, 301; A 1985, 2237; 1987, 198; 1989, 1114; 1991, 2437; 1993, 2302, 2596; 1995, 714, 2562)

THE FOLLOWING CONSTITUTE GROUNDS FOR DENIAL OF LICENSURE, AS SET OUT IN NRS 630.301 THROUGH NRS 630.3065 (cont.):

NRS 630.306 Inability to practice medicine; deceptive conduct; violation of regulation governing practice of medicine or adopted by State Board of Pharmacy; unlawful distribution of controlled substance; injection of silicone; practice beyond scope of license; practicing experimental medicine without consent of patient or patient's family; lack of skill or diligence; habitual intoxication or dependency on controlled substances; filing of false report; failure to report certain changes of information or disciplinary or criminal action in another jurisdiction; failure to be found competent after examination; certain operation of a medical facility; prohibited administration of anesthesia or sedation; engaging in unsafe or unprofessional conduct; knowingly procuring or administering certain controlled substances or dangerous drugs; failure to supervise medical assistant adequately. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Inability to practice medicine with reasonable skill and safety because of illness, a mental or physical condition or the use of alcohol, drugs, narcotics or any other substance.
 2. Engaging in any conduct:
 - (a) Which is intended to deceive;
 - (b) Which the Board has determined is a violation of the standards of practice established by regulation of the Board; or
 - (c) Which is in violation of a regulation adopted by the State Board of Pharmacy.
 3. Administering, dispensing or prescribing any controlled substance, or any dangerous drug as defined in [chapter 454](#) of NRS, to or for himself or herself or to others except as authorized by law.
 4. Performing, assisting or advising the injection of any substance containing liquid silicone into the human body, except for the use of silicone oil to repair a retinal detachment.
 5. Practicing or offering to practice beyond the scope permitted by law or performing services which the licensee knows or has reason to know that he or she is not competent to perform or which are beyond the scope of his or her training.
 6. Performing, without first obtaining the informed consent of the patient or the patient's family, any procedure or prescribing any therapy which by the current standards of the practice of medicine is experimental.
 7. Continual failure to exercise the skill or diligence or use the methods ordinarily exercised under the same circumstances by physicians in good standing practicing in the same specialty or field.
 8. Habitual intoxication from alcohol or dependency on controlled substances.
 9. Making or filing a report which the licensee or applicant knows to be false or failing to file a record or report as required by law or regulation.
 10. Failing to comply with the requirements of [NRS 630.254](#).
 11. Failure by a licensee or applicant to report in writing, within 30 days, any disciplinary action taken against the licensee or applicant by another state, the Federal Government or a foreign country, including, without limitation, the revocation, suspension or surrender of a license to practice medicine in another jurisdiction.
 12. Failure by a licensee or applicant to report in writing, within 30 days, any criminal action taken or conviction obtained against the licensee or applicant, other than a minor traffic violation, in this State or any other state or by the Federal Government, a branch of the Armed Forces of the United States or any local or federal jurisdiction of a foreign country.
 13. Failure to be found competent to practice medicine as a result of an examination to determine medical competency pursuant to [NRS 630.318](#).
 14. Operation of a medical facility at any time during which:
 - (a) The license of the facility is suspended or revoked; or
 - (b) An act or omission occurs which results in the suspension or revocation of the license pursuant to [NRS 449.160](#).
- ↪ This subsection applies to an owner or other principal responsible for the operation of the facility.
15. Failure to comply with the requirements of [NRS 630.373](#).
 16. Engaging in any act that is unsafe or unprofessional conduct in accordance with regulations adopted by the Board.
 17. Knowingly procuring or administering a controlled substance or a dangerous drug as defined in [chapter 454](#) of NRS that is not approved by the United States Food and Drug Administration, unless the unapproved controlled substance or dangerous drug:
 - (a) Was procured through a retail pharmacy licensed pursuant to [chapter 639](#) of NRS;
 - (b) Was procured through a Canadian pharmacy which is licensed pursuant to [chapter 639](#) of NRS and which has been recommended by the State Board of Pharmacy pursuant to subsection 4 of [NRS 639.2328](#); or
 - (c) Is marijuana being used for medical purposes in accordance with [chapter 453A](#) of NRS.
 18. Failure to supervise adequately a medical assistant pursuant to the regulations of the Board.
- (Added to NRS by 1983, 302; A 1985, 2238; 1987, 199, 800, 1554, 1575; 2007, 3046; 2009, 533, 879, 2961, 2962; 2011, 257, 2612)

NRS 630.3062 Failure to maintain proper medical records; altering medical records; making false report; failure to file or obstructing required report; failure to allow inspection and copying of medical records; failure to report other person in violation of chapter or regulations. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.
 2. Altering medical records of a patient.
 3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or willfully obstructing or inducing another to obstruct such filing.
 4. Failure to make the medical records of a patient available for inspection and copying as provided in [NRS 629.061](#).
 5. Failure to comply with the requirements of [NRS 630.3068](#).
 6. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the Board within 30 days after the date the licensee knows or has reason to know of the violation.
- (Added to NRS by 1985, 2223; A 1987, 199; [2001, 767](#); [2002 Special Session, 19](#); [2003, 3433](#); [2009, 2963](#))

NRS 630.3065 Willful disclosure of privileged communication; willful failure to comply with statute or regulation governing practice of medicine. The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Willful disclosure of a communication privileged pursuant to a statute or court order.
 2. Willful failure to comply with:
 - (a) A regulation, subpoena or order of the Board or a committee designated by the Board to investigate a complaint against a physician;
 - (b) A court order relating to this chapter; or
 - (c) A provision of this chapter.
 3. Willful failure to perform a statutory or other legal obligation imposed upon a licensed physician, including a violation of the provisions of [NRS 439B.410](#).
- (Added to NRS by 1983, 302; A 1985, 2238; 1987, 200; 1989, 1663; 1993, 2302)

**7/1/2013 – 6/30/2015 SPECIAL PURPOSE MEDICAL LICENSE
APPLICATION FOR LICENSURE
NEVADA STATE BOARD OF
MEDICAL EXAMINERS**

Post Office Box 7238 Reno, Nevada 89510 Phone (775) 688-2559

Date Received by Board

License No. _____

File No. _____

(For Board Use Only)

With the issuance of this Special Purpose Medical License, the applicant acknowledges:

A Special Purpose Medical License can be issued to a physician who is licensed in another state to perform any of the acts described in subsections 1 and 2 of NRS 630.020 by using equipment that transfers information concerning the medical condition of a patient in this State electronically, telephonically or by fiber optics from within or outside this State or the United States if the physician:

- Holds a full and unrestricted license to practice medicine in that state;
- Has not had any disciplinary or other action taken against him or her by any state or other jurisdiction; and
- Is certified by a specialty board of the American Board of Medical Specialties or its successor.

PLEASE BE AWARE: A physician who holds a Special Purpose Medical License is only authorized to practice medicine electronically, telephonically or by the use of fiber optics. The practice of medicine is defined by NRS 630.020(3) as follows:

1. To diagnose, treat, correct, prevent or prescribe for any human disease, ailment, injury, infirmity, deformity or other condition, physical or mental, by any means or instrumentality.
2. To apply principles or techniques of medical science in the diagnosis or the prevention of any such conditions.
3. To perform any of the acts described in subsections 1 and 2 by using equipment that transfers information concerning the medical condition of the patient electronically, telephonically or by fiber optics from within or outside this State or the United States.

1. Present Legal Name _____
Last First Middle Maiden

List any other name(s) ever used _____

Address:

The **Public Access Address** will be available to the public on the Board's website, and will also be your contact address once licensed. It can be changed if the Licensee completes the Notification of Address Change form available on the Board's website: www.medboard.nv.gov.

The **Mailing Address** that you choose will be used for communication only during the application process. It can be one and the same.

2. Public _____ Address _____

Street City County State Zip

☐ Please check if you choose to have your Mailing Address the same as the Public Address you have entered above.

3. Mailing Address _____
Street City County State Zip

4. Telephone Numbers () Office () Fax () Home () Cellular (Optional)

Email address _____

5. Date of Birth _____ Place of Birth _____ Gender F M
(Month / Day / Year) (City, State, Country)

6. Citizenship: U.S. Citizen _____ Alien Registration # _____ Employment Authorization # _____ Visa _____

Submit a Certified Birth Certificate or original Certificate of Naturalization or current U.S. Passport or copy of the front and back of your Alien Registration card, Employment Authorization card or Visa. Please note: Copy of the document authorizing your name change (marriage license, divorce decree, etc) must be included.

7. Social Security Number _____ Color of Eyes _____ Color of Hair _____ Height _____ Weight _____

NRS 630.197(1)(a) An applicant for the issuance of a license to practice medicine shall include the social security number of the applicant in the application submitted to the Board.

NRS 630.165(5) The applicant bears the burden of proving and documenting his qualifications for licensure.

NRS 630.173(2) The Board has the right to consider information for any malpractice history or derogatory hospital privilege history that is more than 10 years old.

For the purposes of the following questions, these phrases or words have these meanings:

"Ability to practice medicine" is to be construed to include all of the following:

1. The cognitive capacity to make appropriate clinical diagnoses and exercise reasoned medical judgments and to learn and keep abreast of medical developments;
2. The ability to communicate those judgments and medical information to patients and other health care providers, with or without the use of aids or devices, such as voice amplifiers; and
3. The physical capability to perform medical tasks such as physician examination and surgical procedures, with or without the use of aids or devices, such as corrective lenses or hearing aids.

"Medical condition" includes physiological, mental or psychological condition or disorder.

"Chemical substances" is to be construed to include alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction.

FOR ALL "YES" RESPONSES TO THE FOLLOWING QUESTIONS, YOU MUST SUBMIT YOUR SIGNED WRITTEN EXPLANATION(S) ON A SEPARATE ATTACHED SHEET ATTACHED TO YOUR COMPLETED APPLICATION FOR LICENSURE FORM.

8. Do you currently have a medical condition that in any way impairs or limits your ability to practice medicine with reasonable skill and safety?
(If "Yes", attach explanation on separate sheet.) _____ Yes _____ No
9. If you currently have a medical condition which in any way impairs or limits your ability to practice medicine, is that impairment or limitation reduced or ameliorated because of the field of practice, the setting, or the manner in which you have chosen to practice?
(If "Yes", attach explanation on separate sheet.) _____ Yes _____ No _____ N/A
10. If you currently use chemical substances, does your use in any way impair or limit your ability to practice medicine with reasonable skill and safety?
(If "Yes", attach explanation on separate sheet.) _____ Yes _____ No _____ N/A
11. Have you failed to initiate the performance of public service within one year after the date the public service is required to begin to satisfy a requirement of your receiving a loan or scholarship from the federal government or a state or local government for your medical education?
(If "Yes", attach explanation on separate sheet.) _____ Yes _____ No
12. Have you EVER been named as a defendant, or been requested to respond as a defendant, to a legal action involving professional liability, or malpractice, including any military tort claims if applicable? (IF ANSWER IS "YES", YOU MUST COMPLETE FORM B AND FORM 6 – see Application Checklist.)
(If "Yes", attach explanation on separate sheet.) _____ Yes _____ No
- 12a. Have you had a professional liability, malpractice, claim paid on your behalf, or paid such a claim yourself including any military tort claims if applicable?
(If "Yes", attach explanation on separate sheet.) _____ Yes _____ No
13. Have you EVER been arrested, investigated for, charged with, convicted of, or pled guilty or nolo contendere to any offense or violation of any federal (including the Uniform Code of Military Justice), state or local law, or the laws of any foreign country, which is a misdemeanor, gross misdemeanor, felony, violation of the Uniform Code of Military Justice, or synonymous thereto in a foreign jurisdiction, excluding any minor traffic offense (driving or being in control of a motor vehicle while under the influence of a chemical substance, including alcohol, is not considered a minor traffic offense), or for any offense which is related to the manufacture, distribution, prescribing, or dispensing of controlled substances? *Please note that you MUST disclose ANY investigation or arrest, including those where the final disposition was dismissal, or expungement. (If "Yes," attach explanation on separate sheet.)
(If "Yes", attach explanation on separate sheet.) _____ Yes _____ No
14. Have you previously applied for medical licensure in Nevada (including a residency program)?
(If "Yes", attach explanation on separate sheet.) _____ Yes _____ No

15. List names and addresses of all medical schools attended. **HAVE EACH MEDICAL SCHOOL SUBMIT AN OFFICIAL TRANSCRIPT DIRECTLY TO THE BOARD.**
- | Medical School Name | City/State/Country | Place Where
Instruction Received | Dates of Attendance
From (Mo./Yr.) To (Mo./Yr.) |
|---------------------|--------------------|-------------------------------------|--|
|---------------------|--------------------|-------------------------------------|--|

(All information must begin on the application. If more space is needed, please attach separate sheet.)

16. Doctor of Medicine Degree granted by:
- | Medical School Name | City/State/Country | Exact Date of Issuance
(Month/Day/Year) |
|---------------------|--------------------|--|
|---------------------|--------------------|--|

17. List all ACGME* approved graduate medical education you have received as an Intern, Resident or Fellowship in the United States or Canada.
*Accreditation Council for Graduate Medical Education

Postgraduate Year (e.g. PGY1, PGY2, etc.)	Hospital/ Institution	City/State	Specify (I = Internship or R = Residency) (F = Fellowship)	Type of Specialty	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
---	--------------------------	------------	--	----------------------	--

(All information must begin on the application. If more space is needed, please attach separate sheet.)

18. List all non-ACGME approved Fellowship training programs attended in the United States or Canada.

Institution	City/State	Type of Fellowship	Dates of Attendance From (Mo./Yr.) To (Mo./Yr.)
-------------	------------	-----------------------	--

(All information must begin on the application. If more space is needed, please attach separate sheet.)

19. Have you **EVER** been the subject of an investigation (including matters that resulted in no adverse action or outcome to you), have you resigned, been dismissed, or have any actions, form of remediation(s), restrictions, limitations, probations, terminations or any other disciplinary actions ever been imposed on you while participating in any type of training program?
(If "Yes," attach explanation on separate sheet.) _____ Yes _____ No

20. If you graduated from a medical school located outside the United States of America or Canada, list your ECFMG#: _____

21. For each of the following licensing examinations, list the location, parts and dates taken, and scores obtained. (Also include failed examinations.) FOR EACH EXAM TAKEN, HAVE CERTIFICATE OF SCORES SUBMITTED FROM THE TESTING ENTITY DIRECTLY TO THE BOARD OFFICE.

21a. State Written Examination:

Location	Date (Mo./Yr.)	Results (Scores)

21b. NATIONAL BOARD: (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Part Taken	Date (Mo./Yr.)	Results (Two Digit Scores)

(If more space is needed, please attach a separate sheet of paper.)

21c. FLEX (Federation Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Components Taken	Date (Mo./Yr.)	Results (FLEX weighted average)

(If more space is needed, please attach a separate sheet of paper.)

21d. USMLE (United States Medical Licensing Examination): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Step Taken	Date (Mo./Yr.)	Results (Three Digit Scores)	Number of Attempts

(If more space is needed, please attach a separate sheet of paper.)

21e. LMCC (Licentiate of the Medical Council of Canada): (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED EXAMS)

Location	Part Taken	Date (Mo./Yr.)	Results (Scores)

21f. SPEX (Special Purpose Examination):

Location	Date (Mo./Yr.)	Results (Scores)

22. State your scope of practice/specialty (ies):

23. List any and all certifications and re-certifications by a board or sub-board recognized by the **AMERICAN BOARD OF MEDICAL SPECIALTIES** (ALSO INCLUDE ALL INFORMATION PERTAINING TO ANY AND ALL FAILED ATTEMPTS).

Specialty Board	If you are Lifetime Board Certified, indicate "Lifetime"	Certification #	Dates of Certification and/or Recertification (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

24. List any and all licenses (including training licenses and permits) **YOU HOLD OR HAVE HELD** to practice medicine in any state, territory or country:

State/Territory/Country	License #	Date of Issuance (Mo./Yr..)	Status

(All information must begin on the application. If more space is needed, please attach separate sheet.)

25. Have you EVER been denied a license, permission to practice medicine or any other healing art, or permission to take an examination to practice medicine or any other healing art in any state, country or U.S. territory?

(If "Yes", attach explanation on separate sheet.)

____ Yes ____ No

26. Have you EVER had a medical license or license to practice any other healing art revoked, suspended, limited, or restricted in any state, country or U.S. territory?

(If "Yes", attach explanation on separate sheet.)

____ Yes ____ No

27. Have you EVER voluntarily surrendered a license to practice medicine or any other healing art in any state, country or U.S. territory?

(If "Yes", attach explanation on separate sheet.)

____ Yes ____ No

28. Have you EVER been denied membership, asked to resign, or expelled from a medical society or other professional medical organization?

(If "Yes", attach explanation on separate sheet.)

____ Yes ____ No

29. Have you EVER been: a) asked to respond to an investigation; b) notified that you were under investigation for; c) investigated for; d) charged with; or e) convicted of any violation of a statute, rule or regulation governing your practice as a physician by any medical licensing board, hospital, medical society, governmental entity or agency other than the Nevada State Board of Medical Examiners?

(If "Yes", attach explanation on separate sheet.)

____ Yes ____ No

30. Have you EVER surrendered your state or federal controlled substance registration or had it revoked or restricted in any way?

(If "Yes", attach explanation on separate sheet.)

____ Yes ____ No

31. List all hospitals where you have had staff privileges denied, suspended, limited, revoked or not renewed by the hospital. List any and all resignations from any medical staff in lieu of disciplinary or administrative action. (**Please Note:** Do not include suspensions or restrictions for failure to complete hospital medical records, attend hospital department or staff meetings, or maintain required malpractice insurance).

Hospital

Mailing Address

Type of Action

Dates of Action: From (Mo./Yr.) To (Mo./Yr.)

(All information must begin on the application. If more space is needed, please attach separate sheet.)

CHILD SUPPORT STATEMENT

The law of the state of Nevada requires that all applicants for issuance of a license be required to provide the following information concerning the support of a child. You are advised that this questions is part of your application, your response is given under oath, and any response hereto which is false, fraudulent, misleading, inaccurate or incomplete, may result in your application being denied. You must mark one of the following responses, and failure to mark one of the responses may result in denial of your application.

Please place a check mark next to one of the following statements:

____ (a) I am not subject to a court order for the support of a child;

____ (b) I am subject to a court order for the support of one or more children and am in compliance with the order or am in compliance with a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order; **OR**

____ (c) I am subject to a court order for the support of one or more children and am NOT in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

ATTESTATION REGARDING THE REPORTING OF THE ABUSE OR NEGLECT OF A CHILD

I attest and affirm that I am aware of and understand the reporting requirements found in Nevada Revised Statute 432B.220 regarding the abuse or neglect of a child.

____ Yes ____ No

www.leg.state.nv.us/NRS/NRS-432B.html#NRS432BSec220

SAFE INJECTION PRACTICE ATTESTATION

ATTESTATION TO KNOWLEDGE OF AND COMPLIANCE WITH THE GUIDELINES OF THE CENTERS FOR DISEASE CONTROL AND PREVENTION FOR APPLICANT PHYSICIANS

I hereby attest to knowledge of and compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices. I also attest that any person who is currently, or will be under my control as their supervising physician in the future, and who is not licensed pursuant to Chapter 630 of the Nevada Revised Statutes and whose duties involve injection practices, has knowledge of and is in compliance with the guidelines of the Centers for Disease Control and Prevention concerning the prevention of transmission of infectious agents through safe and appropriate injection practices.

http://www.cdc.gov/injectionsafety/IP07_standardPrecaution.html

Applicant: _____

Date: _____

COMMUNICATIONS AFFIRMATION

Consent to accept communications and service of process from the Nevada State Board of Medical Examiners (Board) by electronic mail, for physicians and physician assistants who practice medicine in the state of Nevada via telemedicine and whose physical presence exists outside the state of Nevada or the United States

I hereby agree that as a condition of obtaining or maintaining licensure with the Board, I am willing to accept Board communications to me, to include service of process as defined under Nevada Revised Statute (NRS) 630.344, via electronic mail (more commonly known as e-mail). Further, should the electronic mail address provided below change for any reason, I agree to apprise the Board in writing of my new electronic mail address within 30 days after the change, and that the failure to do so may subject me to a fine or disciplinary action as allowed in NRS 630.244.

Printed Name of Applicant/Licensee: _____

Signature of Applicant/Licensee: _____

Electronic Mail Address: _____

Date: _____

SPECIAL PURPOSE LICENSEE PRACTICE AFFIRMATION

I hereby affirm that I hold a full and unrestricted license to practice medicine in another state; that I have not had any disciplinary or other action taken against me by any state or other jurisdiction; that I am certified by a specialty board of the American Board of Medical Specialties or its successor; that I will maintain my Board certification for the duration of my licensure in the state of Nevada; and that I will be using equipment that transfers information concerning the medical condition of a patient in this State electronically, telephonically or by fiber optics from within or outside this State or the United States.

Signature of applicant

Date

APPLICANT PHOTOGRAPH:

ATTACH A FINISHED PHOTOGRAPH OF PASSPORT QUALITY OF YOUR HEAD AND SHOULDERS ONLY.

PHOTOGRAPH MUST HAVE BEEN TAKEN WITHIN THE LAST SIX MONTHS AND BE AT LEAST 2" x 2" IN SIZE.

SIGN THE PHOTOGRAPH IN INK ACROSS THE LOWER PORTION OF ITS FRONT SIDE.

***CENTER AND ATTACH
PHOTOGRAPH HERE.***

I hereby certify that the attached photograph is a true likeness of me taken within the last six months.

Signature of applicant

Date

APPLICATION AFFIRMATION

I, _____,
(Print your full name)

being duly sworn, depose and say: That the answers to the foregoing questions and statements made in the above application, as well as any and all further explanations contained on any separate attached pages, are true and correct, that I am the person named in the credentials to be submitted, and that the same were procured in the regular course of instruction and examination without fraud or misrepresentation. I understand that if any of my responses on this application are false, fraudulent, misleading, inaccurate, or incomplete, my application for licensure will be denied.

I am responsible to keep the Board informed of any circumstance or event that would require a change to my initial responses provided to the Board in my application for licensure, and which occurs prior to my being granted licensure to practice medicine in the state of Nevada.

Signature of applicant

Date

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

Signature of Notary

FORM A

RELEASE

I hereby authorize all hospitals, medical institutions or organizations, my references, personal physicians, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal or foreign) to release to the Nevada State Board of Medical Examiners any information, files or records required by the Nevada State Board of Medical Examiners for its evaluation of my professional, ethical, physical, and mental qualifications for licensure in the state of Nevada.

DATED this _____ day of _____, 2_____.

Signature: _____

Typed or Printed Name: _____

(NOTARY SEAL)

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____
City State

Signature of Notary

A photocopy of this form will serve as an original.

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238
Reno, NV 89510

or

1105 Terminal Way #301
Reno, NV 89502

LIST OF MALPRACTICE INSURANCE CARRIERS

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, list all malpractice carriers.

Name of Insured: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

Insurance Company: _____

Address: _____

Phone Number: _____

Fax Number: _____

Policy Number: _____

Dates: _____

(If more space is needed, please copy this page or attach a separate sheet.)

Applicant: Each medical school where instruction was received must complete this form. If more than one medical school was attended, photocopies of this blank form may be made and used.

FORM 1

**NEVADA STATE BOARD OF MEDICAL EXAMINERS
VERIFICATION OF MEDICAL EDUCATION**

This certifies that _____
(name of applicant)

was enrolled in _____
(name of Medical School) (Location – City / State / Country)

The following information to be completed by program only.

The undersigned further certifies that the records of this institution show that the applicant attended this institution
from _____ to _____
(month / year) (month / year)

Please check one: ☐ The applicant was granted a medical degree by
☐ The applicant withdrew from

the above named Medical School on _____
(month / day / year)

ADVANCED (TRANSFER) CREDITS – Credits Granted Upon Admission from another Medical Institution

(name of Medical or Professional School) (total credits) (dates attended - month/ year to month/ year)

Signed and the institutional seal affixed this

_____ day of _____, 2 _____

By: _____
(typed name and title of President, Registrar or Dean)

Affix Seal Here

(signature of President, Registrar or Dean) **

Telephone: _____

Fax: _____

Email: _____

** Signatures by personnel other than the President, Registrar or Dean must attach documentation granting authorization to sign in lieu of the President, Registrar or Dean.

Completed form is to be returned by the verifying institution directly to:

PO Box 7238
Reno, NV 89510

Nevada State Board of Medical Examiners

OR

1105 Terminal Way, Ste 301
Reno, NV 89502

Applicant: Each institution where internship, residency and/or fellowship training was received must complete this form.
If more than one institution was attended, photocopies of this blank form may be made and used.

NEVADA STATE BOARD OF MEDICAL EXAMINERS VERIFICATION OF POSTGRADUATE TRAINING

Institution: _____ Affiliated University: _____

Address: _____

Name of Physician: _____

DOB: _____ SS#: _____ Medical School: _____

The following information is to be completed by program only.

IMPORTANT – Program Participation:

- Report incomplete postgraduate years (PGY) separately from those that were successfully completed.
- If the postgraduate year is currently "In Progress", report the expected completion in the "To" field.
- Report Internships, Residencies and Fellowships separately.

PG/Year: _____ DEPARTMENT / SPECIALTY: _____
(e.g., 1, 2, 3, etc.)

<input type="checkbox"/> Internship	From: _____ / _____ / _____	To: _____ / _____ / _____
<input type="checkbox"/> Residency	Successfully Completed? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> In Progress
<input type="checkbox"/> Fellowship		
<input type="checkbox"/> Research		

PG/Year: _____ DEPARTMENT / SPECIALTY: _____
(e.g., 1, 2, 3, etc.)

<input type="checkbox"/> Internship	From: _____ / _____ / _____	To: _____ / _____ / _____
<input type="checkbox"/> Residency	Successfully Completed? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> In Progress
<input type="checkbox"/> Fellowship		
<input type="checkbox"/> Research		

PG/Year: _____ DEPARTMENT / SPECIALTY: _____
(e.g., 1, 2, 3, etc.)

<input type="checkbox"/> Internship	From: _____ / _____ / _____	To: _____ / _____ / _____
<input type="checkbox"/> Residency	Successfully Completed? <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> In Progress
<input type="checkbox"/> Fellowship		
<input type="checkbox"/> Research		

Indicate the correct response to the following three questions:

Accreditation:

1. Is this training approved by the Accreditation Council for Graduate Medical Education (ACGME) or Coordinating Council of Medical Education (CCME) of the Canadian Medical Association? ☐ Yes ☐ No

Unusual Circumstances:

2. Did this individual ever take a leave of absence or break from their training? If yes, please explain. ☐ Yes ☐ No
3. Was this individual disciplined and/or placed under investigation or on probation? ☐ Yes ☐ No

Please explain "Yes" response(s) to questions #2 and/or #3. If necessary, you may continue your explanation on a separate sheet of paper.

Completion of the following is certification that the information above is an accurate account of this individual's records and is true and correct.

This section **MUST** be signed by the Program Director (M.D. or D.O. only)**

**Signature by personnel other than an M.D. or D.O. must attach an authorization letter.

Name: _____ ☐ M.D. ☐ D.O. Title: _____

Signature: _____ Date of Signature: _____

Telephone: _____ Fax: _____ E-mail: _____

Completed form is to be returned by the verifying institution directly to:
Nevada State Board of Medical Examiners

PO Box 7238
Reno, NV 89510

OR

1105 Terminal Way, Ste 301
Reno, NV 89502

Applicant: Each state where licensure is or was held excluding training licenses and permits must be verified. If licensed in more than one state, photocopies of this blank form may be made and used. You may want to contact the state(s) where you were licensed since some states charge a fee for license verifications and some do not. The direct-source verification of your license does not have to be completed on this form. It is a courtesy form which provides the Board's address.

FORM 3

NEVADA STATE BOARD OF MEDICAL EXAMINERS VERIFICATION OF STATE LICENSURE

PART 1 – TO BE COMPLETED BY APPLICANT

Printed Name of Applicant: _____

Address: _____
(street) (apt. or suite #) (city) (state) (zip)

Date of Birth: _____
(month) (day) (year)

I am in the process of applying for medical licensure in the state of Nevada. I hereby authorize release of the following information directly to the Nevada State Board of Medical Examiners at the address below.

(signature of applicant)

PART 2 – TO BE COMPLETED BY LICENSING AGENCY

I certify that _____ who
(name of applicant)

graduated from _____
(name and location of Medical School)

on _____ was granted license number _____ by the state of _____
(date of graduation)

on _____ on the basis of _____
(date of issuance) (Examination: NB / FLEX / USMLE / LMCC / State Licensing examination)

I certify that the above license is:

- _____ Current, in good standing
- _____ Not current, due to non-payment of fees
- _____ Subject to pending disciplinary charges
- _____ Subject to restriction of licensure or practice
- _____ Other (please attach explanation)

I certify that the records in this office indicate that there are not now nor have there ever been any charges filed against the holder of this license.

NOTE: If any portion of this form is deleted or modified, please attach an explanation.

Signature of Certifying Individual

Title of Certifying Individual

Licensing Agency Name

Date of Signature

Completed form is to be returned by the verifying institution directly to:

Nevada State Board of Medical Examiners
PO Box 7238 OR 1105 Terminal Way, Ste 301
Reno, NV 89510 Reno, NV 89502
(775) 688 – 2559

FORM 4 and FORM 5
are intentionally not included
in the application for the
Special Purpose Physician License

If you answered affirmatively to questions #12 and/or #12a on the Application for Licensure, submit this form to all malpractice carriers verifying all coverage within the past 10 years. If more than one malpractice carrier, photocopies of the blank form may be made and used.

FORM 6

MALPRACTICE INSURANCE CARRIER VERIFICATION

Insurance Carrier Information:

Name of Insured Physician: _____

Name of Insurance Company: _____

Address: _____

Phone: _____ Fax: _____

.....
(To be completed by verifying agency only)

Policy Number: _____

Policy Period From: _____ To: _____

****Please provide a loss history report with this verification.

Claims Experience:

Has this Physician had a settlement paid on his/her behalf? ____ No ____ Yes

If "yes", please provide the following information:

Occurrence

Date

Status

Date Closed

Indemnity

Amount

Description of Claim: _____

Occurrence

Date

Status

Date Closed

Indemnity

Amount

Description of Claim: _____

Insurance Carrier Agent:

Print Name and Title

Telephone

Signature of Agent

Please return completed form to:

Nevada State Board of Medical Examiners
P.O. Box 7238, Reno, NV 89510 (Mailing Address)
1105 Terminal Way #301
Reno, NV 89502 (Physical Address)
Phone: (775) 688-2559

RELEASE

I hereby authorize the above named institution to release any information, files, or records required by the Nevada State Board of Medical Examiners for licensure in the state of Nevada.

Medical Doctor (applicant) signature and date

State of _____ County of _____

Subscribed and sworn to before me this _____ day of _____, 2_____.

Notary Public for the State of _____

My Commission Expires: _____

Residing at: _____ City _____ State _____

Signature of Notary

**PERMISSION TO SEEK CRIMINAL BACKGROUND INVESTIGATION REPORT
AND TO OBTAIN AND USE A SET OF MY FINGERPRINTS IN THIS REGARD**

I understand that all applicants applying for licensure with the Nevada State Board of Medical Examiners, pursuant to Nevada Revised Statutes Chapter 630, must submit a full set of his/her fingerprints, along with an authorization for the Nevada State Board of Medical Examiners to forward his/her fingerprints to the Department of Public Safety Records and Technology Division and to the Federal Bureau of Investigation for a state and federal criminal background investigation and report.

I herewith and hereby grant permission and fully authorize the Nevada State Board of Medical Examiners to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports.

I UNDERSTAND THAT THE COSTS OF FINGERPRINTING, THE BACKGROUND CHECK AND THE REPORT SHALL BE AT MY OWN EXPENSE.

Dated this _____ day of _____, 2____.

Signature of Applicant

Print Name

By signing my signature on the line below, I do hereby understand that I must timely submit my fingerprints to the Nevada State Board of Medical Examiners in order for the Board to submit a complete set of my fingerprints to the Department of Public Safety Records and Technology Division for submission to the Federal Bureau of Investigation for their reports. Failure to do so could result in disciplinary action, up to and including immediate summary suspension of my license. NRS 630.167.

Signature of Applicant

Date

Return this form to:

Nevada State Board of Medical Examiners
1105 Terminal Way, Ste. 301, Reno, NV 89502

or

P.O. Box 7238
Reno, NV 89510

CREDIT CARD AUTHORIZATION FORM

If mailing or faxing this page separately from the application, please mail to:

Nevada State Board of Medical Examiners

P.O. Box 7238

Reno, NV 89510-7238

or fax to:

775-688-2321

Please type or print legibly.

Name of Applicant: _____

Method of Payment: ☐ MasterCard ☐ Visa ☐ American Express ☐ Discover

Name on Credit Card: _____

Business Name (if applicable): _____

Credit Card Billing Address:

Phone Number: _____

Credit Card Number: _____

Expiration Date: ____ / ____
 (MM) (YYYY)

I authorize the Nevada State Board of Medical Examiners to charge the above credit card for a one-time payment in the amount of \$ _____, and an additional 2% service fee.

Printed Name: _____

Authorized Signature: _____ Date: _____